SECTION 3: GENERAL CARE OF THE SICK CHILD

3.2 Hygiene

3.2.3 Abdominal Stoma Care (Ileostomy and Colostomy)

Aims

1. To protect the peristomal skin, contain the output and control odour.
2. To accurately assess the stoma and promptly detect complications.

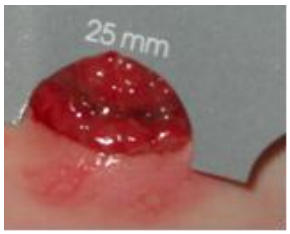
Key points

1. All patients with stomas should be referred to the Clinical Nurse Consultant (CNC) Stomal Therapy (Page 8009).
2. Also refer to the PMH Stoma Assessment Quick Reference Guide, available in ward areas as per link.
3. The Stomal Therapy CNC may do the original pouch change postoperatively.
4. A full pouch leads to leakages, therefore empty when no more than one third full or distended with air.
5. Change appliance immediately if leakage occurs as leakage can damage the skin.
6. The equipment should be stored in the patient's bedside cupboard, or in the patient's own storage bag. For patients requiring infection control precautions place only the required equipment for the next stoma cares/pouch change in the patient's room.

Equipment

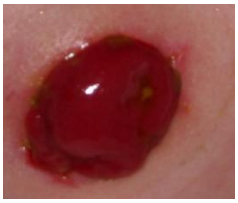
- Clear drainable appliance
- Scissors
- Measuring guide
- Warm water
- Disposable (non- scented) wipes
- Receptacle – kidney dish
- Paper rubbish bag
- Disposable gloves
- Adhesive remover wipe
- Skin barrier wipe (no sting barrier

Pouch Change

Procedure	Additional Information
Position the patient to allow for easy access and drainage of the pouch.	
Perform hand hygiene and don gloves.	
Empty stoma pouch into receptacle.	A syringe and extension cannula can be used to empty the pouch if necessary.
Measure and record the volume on the fluid balance chart.	An accurate record of fluid balance is important to monitor the patient for signs of dehydration.[1]
Remove the old pouch: carefully peel it off the patient's skin in a downward direction from top to bottom with one hand, whilst supporting the skin with other. Discard the used pouch into the waste bag.	Use a non-alcoholic adhesive remover wipe if necessary. Removing the pouch in this manner prevents faecal matter leaking unduly onto the patient's skin.[2]
Clean the stoma and surrounding skin using warm water and disposable cleansing cloth. Ensure the entire old adhesive is removed. Dry skin thoroughly.	The stoma and peristomal skin are unsterile, tap water is adequate for cleansing.[3, 4]
Measure stoma size using the measuring guide and cut aperture in the baseplate 1-2 mm larger than this measurement. 	A template cut to the correct size is used to trace the selected size on the appliance. If the aperture is too large the peristomal skin can easily become excoriated.[3, 5] If the aperture is too small it can result in trauma to the actual stoma.
Apply the pouch starting below the stoma and then over the stoma.	Ensure the stoma is tucked inside the opening of the pouch (none is sticking on the adhesive)
Ensure good adhesion by placing gentle pressure immediately around the stoma with your finger.	It is important to achieve a good seal to prevent leaks.[5]
Ensure bottom of pouch is closed securely.	
Ensure patient is comfortable. Dispose of used equipment in clinical waste. Perform hand hygiene.	
Document pouch change in patient's progress notes and nursing care plan.	

Stoma Observations

- Include stoma observations in the shift to shift clinical handover.
- Document any deviations from normal in the patient's progress notes and liaise with CNC Stomal Therapy if any concerns.

Procedure	Additional Information
Colour The stoma should appear pink/red colour and be moist and shiny in appearance.[2, 3, 5] 	Any deviation from this colour should be documented in the patient's progress notes. Report to the Stomal Therapy CNC (page 8009) and the treating Consultant.
Oedema	Immediately postoperatively the stoma may appear oedematous but this settles after 6-8 weeks.[3]
Bleeding – excess bleeding from the stoma or mucocutaneous junction should be documented and reported to the Stomal Therapy CNC.	It is normal for there to be some blood at the junction of the stoma to the skin postoperatively.[2]
Mucocutaneous Junction – disruption to this junction should be documented and reported to the Stomal Therapy CNC	This is where the abdominal skin and the stoma attach. It should be continuous with sutures evident.
Peristomal skin – check for • Redness • Integrity • Pain	This is the skin around the stoma. It should be similar to the skin on the other side of the abdomen in appearance and be intact without any redness or discomfort.[2, 6]
Presence of bridge – document this in patient's progress notes. 	A bridge is a plastic rod used to support a loop stoma. It is removed by the Stomal Therapy CNC after 5 days or at instruction of the surgeon.[7]
Degree of protrusion – the stoma should protrude 5-10mm from the skin level.	The degree of protrusion can be described as either flush (at skin level), protruding (state length), or retracted (below skin level).[8]

Procedure	Additional Information
Output – Observe amount, colour and consistency. Record on fluid balance chart and in the patient's progress notes.	Initial postoperative output may be haemoserous.[9] • Ileostomy output will vary from thin to thick paste like consistency. It is important to monitor ileostomy output as the patient can become dehydrated quickly and have electrolyte imbalance. • Colostomy output is soft stool. • Ileal conduit output should be clear urine. It may contain some mucus as a piece of bowel is used to form the conduit.
Flatus – Following formation of a bowel stoma, document when the first flatus is passed postoperatively.	Passage of flatus indicates return to normal bowel function.

Related policy, procedures and guidelines.
Pouching of Wound Drains and Fistulae
Prevention and Management of Excoriated Skin

Useful Resources
Stoma Assessment Quick Reference Guide
Journal of Stomal Therapy Australia (access via Library Resources)

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